Government of Saskatchewan

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Our Children. Our Promise. Our Future.

Early Childhood Development Progress Report 2002/2003

Contents

Message from the Ministers 2

Executive Summary 3

A Profile of Saskatchewan Children and Families 4

Early Childhood Development Strategy (ECD): A Brief History 7

ECD Strategy: Progress Made in 2002-03 8

- KidsFirst 8
- KidsFirst Voices 11
- Early Learning and Care 12
- Prekindergarten 14
- Early Childhood Intervention Program 14
- Infant mortality risk reduction initiatives 15

ECD Strategy: The Path Forward 16

Appendix A: Summary of Investments 2002-03 17

Appendix B: Early Learning and Child Care 2002-03 18

Appendix C: KidsFirst Strategic Plan 2002-03 20

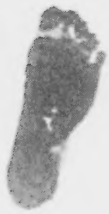
Appendix D: Indicators of Child-Well-Being in Saskatchewan 21

Appendix E: Data Specifications 35

Message from the Ministers

Children are our most precious resource. It is now well understood that the earliest years of life are the most critical to success in adulthood. The Government of Saskatchewan is committed to providing all of our province's young children, and their families, with the support and encouragement they need to thrive.

Over the past ten years, the Government of Saskatchewan has placed increasing emphasis on building a range of supports for vulnerable children, from birth to age five, and their families. The Early Childhood Development (ECD) Strategy, approved in 2000, brings together resources and knowledge from a variety of sectors to provide a coordinated, comprehensive approach to assist vulnerable families to nurture their children.



In conjunction with initiatives such as the Métis and Off-Reserve Strategy, School^{PLUS} and Building Independence, the ECD Strategy demonstrates a commitment by government to create multisectoral partnerships which address, in a comprehensive manner, the issues encountered by Saskatchewan children and their families.

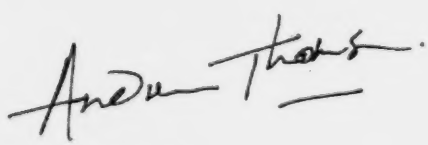
The Early Childhood Development Progress Report 2002 - 2003 describes the steps being taken under the ECD Strategy to bring about a positive difference in the lives of Saskatchewan children. The report also provides a starting point for reporting the Government of Saskatchewan's commitment to early learning and child care. We have accomplished much and our goal remains clear: to provide all children with the best possible start in life.

Joanne Crofford

Minister of Community Resources and Employment

John T. Nilson, Q.C.

Minister of Health



Andrew Thomson

Minister of Learning

Executive Summary

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The Government of Saskatchewan is pleased to present its second annual Progress Report on Early Childhood Development (ECD). This Report informs the Saskatchewan public of the investments and progress made on the province's Early Childhood Development Strategy during 2002-03.

The report presents an overview of factors which affect Saskatchewan children's health, development and well-being. Saskatchewan residents are generally healthy and prosperous, but significant numbers of children are growing up in social and economic circumstances which make it difficult for them to reach their full potential. On the positive side, our infant mortality rate is declining and recent data indicates that more Aboriginal youth are completing high school than ever before.

The fiscal year 2002-03 was an exciting and productive one for the ECD Strategy. KidsFirst — the first program initiative implemented under the ECD Strategy in Saskatchewan — moved into its second year. KidsFirst provides a range of support services to vulnerable families, including pregnant women and children up to age five. Over 1,000 families in the nine KidsFirst areas were referred for assessment and, over the course of the fiscal year, 850 families were in the program.

KidsFirst home visitors made a total of 15,800 home visits or direct contacts with families. Mental health and addictions staff dedicated to KidsFirst were in place by the end of the fiscal year. Also by the end of the fiscal year, parent support programs were implemented in all communities. Work on a strategic plan and information system for KidsFirst is ongoing.

Early learning and care is an important part of Saskatchewan's ECD Strategy. The Government of Saskatchewan is committed to creating a comprehensive, coordinated approach to early learning and care which will meet the needs of Saskatchewan's most vulnerable children. In 2002-03, additional investments in wages and professional development for early childhood educators were made and additional funds were provided for start-up and equipment grants in licensed family childcare centres across the province.

Saskatchewan's Prekindergarten program, established in 1996-97, provides quality early learning experiences to preschool-age children. Since 2001-02, four new communities with significant numbers of vulnerable children have been given ECD funding to set up Prekindergarten programs.

The Early Childhood Intervention program, which serves children with disabilities, received ECD funding for 108 new spaces. The Infant Mortality Risk Reduction Initiative received ECD funding to assist five regions to assess their needs and implement programs.

In total, $6.8 million was provided to nine KidsFirst sites in Saskatchewan. An additional $2.2 million was provided for related programming including infant mortality risk reduction, child care, special needs services, Prekindergarten and program development and support.

Detailed appendices are included in this year's Progress Report. Appendix A shows the Summary of Investments. Appendix B includes baseline information on Early Learning and Care expenditures and programs in 2002-03. Appendix C presents the KidsFirst Strategic Plan.

New data on the well-being of Saskatchewan children is included in Appendices D and E. Last year's report provided a baseline to help track changes in the well-being of Saskatchewan's children over time. This year's data provides a snapshot of Saskatchewan children two years later. Future reporting on these well-being indicators will be timed to coincide with the data collection cycles of the National Longitudinal Study of Children and Youth (NLSCY). Over the long term, this data will help determine whether we are making progress in addressing the needs of children and families across Canada and in our province.

A Profile of Saskatchewan Children and

The first five years of a child's life lay the groundwork for the years to come. A child who grows and thrives on all levels -- physical, intellectual, social, emotional and spiritual -- has a strong base to draw on for the rest of his or her life.

Many factors influence a child's health and development in the early years, including: the mother's age and health during pregnancy; birth weight; parents' education, employment status and income; family, community and government supports; and the type of housing and neighbourhood in which the child lives.

The following section of this Progress Report provides an overview of how these factors are affecting the lives of Saskatchewan's young children and their families. To provide the most complete picture possible, data has been drawn from a variety of sources. While the years in which it was collected range from 1996 to 2003, the data is reasonably current and, collectively, presents a useful snapshot of the present situation. For more complete statistical information, see Appendices D and E.

Teen pregnancy

Teen pregnancy lessens the mother's chances of finishing high school and increases her and her child's chances of living in poverty. Low birth weight and subsequent health problems are also more common in babies born to teen mothers.

Saskatchewan continues to have the highest teenage birth rate of all the Canadian provinces. In 1999, 37.3 births per thousand were to 15 to 19-year-olds. This is nearly double the Canadian rate but substantially less than the 44.5 per thousand figure for Saskatchewan in 1995.

Income

Studies show that people at each level of the income scale are healthier and live longer than those at a lower level. Higher incomes provide people with the ability to cover their material needs, make more choices, and have more control over their lives.

In 2000 in Saskatchewan, 47,000 children lived in low income families (17.9 per cent). In that year, Saskatchewan had the fourth lowest percentage of children living in low-income families compared to other Canadian provinces (territories excluded).

People receiving social assistance tend to be the poorest of the low-income population. As of September 2002, there were more than 29,500 cases (individuals and families) on social assistance; 36 percent were families including more than 22,000 children. Eighty-three percent of the families on social assistance were

single parent families. Forty-one percent of the Saskatchewan Assistance Plan (SAP) caseload was of Aboriginal ancestry.

Education

A strong link exists between an individual's level of education and employment opportunities. Those who do not finish high school are more likely to be unemployed.

Families

Those who earn both a high school diploma and obtain further education have the lowest unemployment rates. There is also a strong link between an individual's level of education and health status.

In 2002, Saskatchewan had one of the lowest high school drop out rates in Canada. Almost 80 percent of Saskatchewan students completed Grade 12.

The percentage of Saskatchewan Aboriginal students who complete Grade 12 is increasing: in 1992-93, 30 percent of Aboriginal students completed Grade 12 within three years of entering Grade 10; by 1998-99, 41.9 percent of Aboriginal students graduated within three years of entering Grade 10. Recent data shows that, within eight years of entering Grade 10, more than 50 percent of Aboriginal students complete Grade 12.

Health

Personal health practices, such as smoking, use of alcohol and other drugs, healthy eating and physical activity have a profound effect on health and well-being. Parents' modelling of healthy or unhealthy behaviours can influence the adoption of these behaviours by children.

Recent data indicates that more than 80 percent of Saskatchewan residents have very good or perfect functional health[1] status. However, the percentage of Saskatchewan residents with this health status is slightly lower than the Canadian average. In addition, Aboriginal people in Saskatchewan rate their health lower than non-Aboriginal people. Based on a 2001-02 community health survey, 23 percent of off-reserve Aboriginal people rated their health fair or poor compared with 12 percent of non-Aboriginal people.

Saskatchewan residents have a higher rate of consumption of alcohol than the national average. Close to 30 percent of Saskatchewan residents consume five or more drinks, 12 or more times per year. This compares to 20 percent of Canadians with these alcohol consumption patterns. The situation is of concern among Saskatchewan youth, with 40 percent of 12 to 19-year-olds consuming this amount of alcohol, compared to the national average for youth of 30 percent.

Employment

Employment status and conditions in the work environment can affect the health of parents and their children. Generally speaking, people are healthier when they are employed, have a high degree of control over their work circumstances and have fewer stress-related job demands.

In Saskatchewan in August 2003, 70.2 percent of the population was in the labour force and the unemployment rate was 5.7 percent.

Labour force participation is lower for Aboriginal people. Based on 1996 Census data, only 38 percent of Saskatchewan Aboriginal people were in the labour force, compared to 65 percent of Saskatchewan non-Aboriginal people.

[1]Functional Health is based on a description and a valuation of health according to the Comprehensive Health Status Measurement System. Source: Statistics Canada, CANSIM II data, 2002, as reported in Saskatchewan Education Indicators, 2002.

Working Together with Saskatchewan Health

Saskatchewan Health recognizes that health promotion and disease prevention will provide long-term benefits, and is committed to building strong partnerships to ensure the success of KidsFirst.

Saskatchewan Health is working with health regions and their partners to increase the emphasis on population health promotion. Health regions will work collaboratively with other sectors in their communities. This will provide opportunities for communities to strengthen their knowledge and skills so that they can improve the social and economic conditions and physical environments that contribute to health.

The Action Plan for Saskatchewan Health Care, ***the province's long-term plan for health services, encourages many specific initiatives that directly and indirectly improve the health of our children. Since the plan was unveiled in December 2001, access to primary health services has increased, four new health centres have been approved or opened in northern and aboriginal communities, the toll-free 24-hour HealthLine was launched, and treatment and prevention programs are being developed in key areas, including Fetal Alcohol Spectrum Disorder. Significant progress continues to be made to provide families with the resources they need to raise healthy children.***

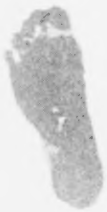
For more information, or to see the September 2003 **Progress Report on The Action Plan** ***for Saskatchewan Health Care, visit: www.health.gov.sk.ca***

Twenty-five percent of Saskatchewan youth under 14 are Aboriginal yet they comprised almost two-thirds of all children in care in 1998.

Housing

Quality of housing affects people's health and well-being. In 1996, 15 percent of Canadian children lived in housing that did not meet accepted standards of affordability, suitability and adequacy. Children living in rental accommodations were more likely to be living in substandard housing (36 percent of rental households compared to seven percent of owner households) and consequently were at greater risk for injury.

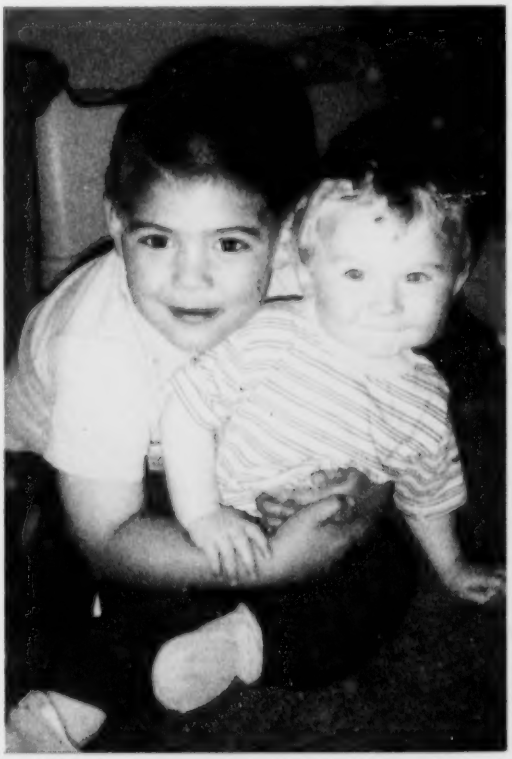
Saskatchewan has a lower proportion of renters than other provinces, but it has some of the oldest housing stock in Canada. The proportion of Saskatchewan houses in need of major repair is above the national average. Houses in need of major repair are much more common on reserves and in the North.



Aboriginal people living on reserves with less than a Grade 12 education had the lowest employment rate, at 30 percent; those living off reserve with at least a Grade 12 education had the highest employment rate, at 43 percent. The largest gap in employment rates was among young Aboriginal women (15 to 24 years of age) where 21 percent were employed compared with 58 percent of non-Aboriginal women.

Children in Care

The psychological stresses of poverty sometimes make it difficult for parents to cope. Children may suffer from neglect and abuse as a result. Between 1995 and 2000, more than 66 percent of families receiving some form of child protection services were on social assistance. Of families receiving protective services for one year, nearly 60 percent were on social assistance. Where families had been receiving protective services for five years, 94 percent were on social assistance.



ECD Strategy

A Brief History

Over the past 10 years, the Government of Saskatchewan has been working with communities throughout the province to develop a holistic, community-based approach to meeting the needs of children and families.

During the 1990s, the province's experience with Saskatchewan's Action Plan for Children increased our awareness of the early childhood needs of families and children. In 1999, a public discussion paper, *Building on Community Success - Creating a Long-term Plan for Saskatchewan's Youngest Children and their Families*, was released. It was clear from the response to the discussion paper that early childhood development was a public concern and that it was time to focus renewed attention on this issue. The province's ECD Strategy was approved in 2000.

Saskatchewan's progress on early childhood development is the result of partnerships that have been created at several levels. The provincial Departments of Learning, Health, Community Resources and Employment, and Government Relations and Aboriginal Affairs have worked together to develop and implement the ECD Strategy. As well, the provincial government has engaged selected communities across the province to implement KidsFirst, the first program implemented under the Strategy. Through the ECD Strategy, additional funding is also provided for children with special needs, wages and training enhancements in the child care sector, Prekindergarten programs and programs aimed at reducing infant mortality in targeted communities.

Saskatchewan has also worked with the federal government and with other governments across Canada to ensure resources are available, information is shared and that there is consistency in public reporting.

Saskatchewan's ECD Strategy was given a boost in September 2000 when the First Ministers released their joint Communiqué on Early Childhood Development. In the Communiqué, First Ministers at the federal, provincial and territorial level affirmed their commitment to the well-being of children and set out their vision of early childhood development as an investment in the future of Canada. In their announcement, the First Ministers agreed to enhance services in four key areas:

1. promoting healthy pregnancy, birth and infancy;
2. improving parenting and family supports;
3. strengthening early childhood development, learning and care; and;
4. strengthening community supports.

As part of this commitment, the federal government agreed to transfer approximately $70 million over five years to the Saskatchewan government to support new or enhanced ECD programming. This additional funding began in 2001-02. Since then, federal financial support has been announced for two more years (2006-08) bringing the total for ECD in Saskatchewan to more than $100 million over seven years.

In March 2003, ECD services in Saskatchewan were given further support when Federal, Provincial and Territorial Ministers Responsible for Social Services announced they had reached an agreement on a Multilateral Framework on Early Learning and Child Care. This initiative provides for an additional investment in early learning and care - a major part of the third key area identified in the First Ministers ECD Communiqué, "strengthened early childhood development, learning and care." Under the Early Learning and Child Care initiative, the federal government will transfer an additional $28 million to Saskatchewan specifically for early learning and care between 2003 and 2008.

Working Together with Community Resources and Employment

The ECD Strategy complements the provincial government's Building Independence Initiative, which began in 1998. Building Independence provides employment transition support to people in disadvantaged circumstances so that they can become more self-sufficient and improve their overall well-being. Vulnerable families with young children require specific additional supports to enable them to train for, find and keep employment while caring for their children. The ECD Strategy is a key part of helping vulnerable Saskatchewan families achieve independence.

In addition to KidsFirst, a number of programs are designed to assist low income individuals and families to gain independence. These programs provide financial assistance to help families with the cost of raising children; ensure that adequate health care is available to low income families; subsidize child day care for those in deepest poverty; and support adults to train for, find and keep employment.

Visit:
www.dcre.gov.sk.ca/mediaroom/pdfs/Phase1Background.pdf

www.dcre.gov.sk.ca/mediaroom/pdfs/Phase2Background.pdf

Progress made in 2002-03

KidsFirst

KidsFirst is the first new program implemented under Saskatchewan's Early Childhood Development (ECD) Strategy. The purpose of the KidsFirst program is to assist vulnerable families to develop the capacity to nurture their children.

The program focuses on providing services to vulnerable families, including pregnant women and children up to age five. In the past, government programs were frequently directed at children who were physically or mentally challenged. KidsFirst programming is aimed at a broader range of vulnerable families, many of whom live in low-income neighbourhoods and communities. Involvement of Aboriginal people and organizations is encouraged to ensure services are culturally relevant.

The framework for management of the KidsFirst program is provided by government. Within this framework, however, each KidsFirst community has worked to respond to local needs. Each community has established a KidsFirst Management Committee and has selected either a local school division or health region to coordinate efforts.

KidsFirst Management Committees are made up of local representatives from the health regions, school divisions, regional Department of Community Resources and Employment (Social Services) offices, First Nations and Métis organizations and, in some cases, other groups. KidsFirst program managers have been hired in each of the communities.

KidsFirst program components are:

- Prenatal casefinding focused on preventing Fetal Alcohol Spectrum Disorders (FASD);
- A universal, hospital based screening program for newborns and their families;
- In depth assessments;

- An intensive home visiting program;
- Enhanced early learning opportunities;
- Increased access to child care;
- Dedicated mental health and addiction services; and
- A range of community-based parent supports including literacy, parenting and nutrition education.

KidsFirst Communities

ECD Strategy
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KidsFirst Communities

Program Highlights

Participation in KidsFirst grew steadily over the 2002-03 fiscal year.

By March 2003, hospitals in eight of the nine KidsFirst-targetted communities were screening newborns and their families for KidsFirst eligibility.

Sixty-four percent of screens on families residing in targeted areas, or 1,174 families, were referred for assessments. Pregnant women who may be using alcohol and/or drugs are admitted to the program without an assessment.

On average, from October 2002 to March 2003, 80 new families joined the program each month and 26 families left the program each month. Over the course of the fiscal year, 850 families participated in the program and a total of 15,800 home visits or direct contacts with the families took place. By the end of the fiscal year, 670 families remained in the program.

KidsFirst Principles

- ***Services are strength-based, focusing on partnership with the parents, their wants and needs, and their strengths and capacities.***
- ***Participation in the program is voluntary.***
- ***Aboriginal organizations are included in the development and implementation of the program to ensure that programs offered are culturally appropriate.***
- ***The program utilizes existing community programs and services, to ensure that the program develops in an intersectoral and integrated manner.***
- ***Programs are innovative and flexible to respond to the needs of the families.***

Implementation of the child care and early learning components in all sites was completed this year. At the end of March 2003, there were 104 child care spaces funded by KidsFirst and 104 early learning spaces[2]. Over the course of the year, these spaces may be utilized by several different families and some spaces may be shared between more than one family.

Mental health and addictions staff dedicated to the KidsFirst program were in place by the end of March 2003.

Parent support programs were implemented in all communities by the end of March 2003. Programs are based on parent-identified need and vary from community to community. In all communities, parents have asked for effective parenting and nutrition programs and these have been offered. Programs aimed at increasing social support networks have included parent coffee times and family barbecues. Literacy programs have also been implemented in many of the communities; transportation and child care needs have been addressed.

[2] *These include both newly-created and existing spaces.*

Many of the parent support programs are offered to the broader community which allows larger support networks to develop for the families.

KidsFirst staff have also been active in implementing programs which benefit the broader community. For example, three communities have assisted with the development of Good Food Box programs which provide nutritious food, such as fruits and vegetables, at reduced cost, to families once per month.

Working Together with Saskatchewan Learning

Support for vulnerable children does not end when they begin school. School^{PLUS} is a Government of Saskatchewan initiative, begun in 2001, designed to strengthen the capacity of schools and to improve the educational outcomes for every Saskatchewan child. Within School^{PLUS}, schools are seen as key hubs of community life that can offer supports to families and children from the pre-school years through to the transition to adulthood. School^{PLUS} more actively involves family and community members to help provide all children and young people with the supports they need for healthy development and learning success. Supports may include health, nutrition, recreation, culture, social and justice services for children and their families, as well as advanced learning opportunities for adults.

By keeping all children in school and helping each child achieve educational success, improved life outcomes can be assured for many children and families who now live on the margins of mainstream society.

The ECD Strategy and School^{PLUS} are all part of a continuum which aims to raise healthy, engaged and socially responsible citizens.

Visit: www.sasked.gov.sk.ca/k/pecs/splus/index.htm
or: www.schoolplus.gov.sk.ca

KidsFirst Voices

"After being in our program for three months, a young mom said to her home visitor: " 'I used to think that my kids could never be a doctor or a lawyer or a teacher. But, thanks to you, I know that my kids can be anything they want to be!' "

A KidsFirst Program Manager

"One (of the moms) in my families recently went back to school. She was very upset about putting her child into daycare, but having daycare available has helped her achieve her goal of completing her education. She shared with me today how the support of KidsFirst has been so key to her ability to strive for her goals. She expressed that she would not have returned to school or gotten off social assistance had it not been for KidsFirst."

Julie Hersey-Bergen, Home Visitor, KidsFirst Saskatoon

"Thank you for the support and great friendship that has developed between us. Treatment is wonderful and has been so good for me. I'm actually happy and it's been such a long time since I have felt good about the direction my life has taken."

Nicole, a KidsFirst mom

"My grandson, he can't stop talking about KidsFirst. He used to be so angry with his girlfriend for getting pregnant (and she laughs, commenting on how she did that all by herself). Now he is looking forward to being a dad. He makes sure she takes her vitamins, goes to her appointments and even helps around the house so she can rest. I don't know what you did, but it worked!"

Grandmother of a KidsFirst participant

"KidsFirst has been a great source of support. You really have been a big help and I thank you for it. Even just talking like we did last night really helps. Things you said really made me think. It's nice having someone to talk to again."

Michelle, a KidsFirst mom

"It brings tears to my eyes when I think about how far this mom has come. She attends every KidsFirst activity and networks with other moms. She is in treatment for her addiction and meeting lots of supportive people there, and she soaks up any information about parenting we give her. She went from complete isolation to developing all kinds of strong supports. The program has made an incredible difference in the life of this mom and her kids."

Krista Bakke, KidsFirst Program Manager

"Thank you for inviting me to the Community Baby Shower. It was the first time that I was proud to be a mom. And the first time that someone took the time to care about my children and me. I had so much fun. Can I help you plan the next one? I think I could do very good at planning because I know what it feels like to have someone think you're special!"

A KidsFirst mom

"This is the first time that any agency has ever asked us what we think. Usually, we get told what we can do and how to do it. This is the first time anybody took the time to listen to us, and help us develop things for our community."

A KidsFirst community

First Voices

Early Learning and Care

Numerous studies have shown the connection between care and learning in early childhood. We now know that young children develop and learn best when they grow up in nurturing environments. For young children, in particular, learning and care are inseparable.
A grandparent who talks to a baby while cuddling and holding her is providing care as well as an opportunity to learn language.

In the earliest years of life, families have the primary responsibility for their children's care and learning. But everyone shares an interest in children's development for the young children of today are the adult citizens of tomorrow. The common interest in children is expressed, in part, through the supports available to parents from extended families, neighbourhoods, communities and governments.

Clarifying the Terms

Until recently, the term *child care* referred most often to programs whose primary purpose is to support parents while they work or attend school. In Saskatchewan, as elsewhere, many parents are balancing their commitment to their young children with their own employment, education or training. *Child care* or *daycare* programs usually operate full days, sometimes for extended hours, to accommodate parents' work schedules.

The term *preschool education* referred most often to *nursery schools*, *play schools* and *prekindergarten* programs. These usually operate for two or three hours per day, two to four days per week and their primary purpose is to provide early learning experiences for preschool-age children. Just over 40 percent of Saskatchewan families with children between three and five years of age enroll their children in a preschool program.

Early learning and care is a relatively new concept. It brings together a recognition of the need for childcare so that families can support themselves, with a recognition of the need for high quality early learning opportunities for all children.

The Saskatchewan Scene

Saskatchewan has many excellent programs which provide early learning and care for young children. These include licensed child care centres, licensed family child care homes, private child care arrangements, community-based nursery/play schools, library and recreation programs, early intervention home visiting programs, family support programs such as KidsFirst and Prekindergarten programs supported through Saskatchewan Learning. These programs have evolved over the years in response to families' and childrens' needs and have been shaped by various community and government initiatives.

While many services are available, future development needs to strive for a more comprehensive, integrated and efficient system.

According to a survey of Saskatchewan families conducted in 2001, about 75 percent of preschool-age children regularly spend part of their day with a caregiver who is not a parent. On average, Saskatchewan preschoolers spend about 25 hours a week in the care of others. For the most part, these are private arrangements with individual caregivers who are relatives, friends or neighbours.

Licensed spaces in child care centres and homes are available for approximately six percent of Saskatchewan preschoolers.

With over 40 percent of families enrolling their children in preschool programs, Saskatchewan parents clearly place a high value on early learning opportunities. Preschool programs are available free of charge in some neighbourhoods; programs in other areas charge a fee.

The research is clear: children who receive high quality early learning and care benefit tremendously. Those who receive poor quality learning and care are affected negatively. The quality of care Saskatchewan's young children are receiving is critical to their development.

Towards a Coherent System - Provincially, Nationally and Internationally

Saskatchewan is committed to creating a comprehensive, coordinated approach to early learning and care. Our efforts are consistent with those of many other provinces and countries. There is growing recognition that a more strategic approach to early learning and care is a benefit - both to families and to society as a whole.

Nationally, the Multilateral Framework on Early Learning and Child Care, agreed to by federal, provincial and territorial Ministers Responsible for Social Services in March 2003, is a milestone. It underlines the intention of governments in Canada to begin moving towards a more integrated approach and provides support for the direction Saskatchewan is taking.

Internationally, other countries are becoming aware of the importance of early learning and care. Over the past five years, the Organization for Economic Co-operation and Development (OECD) has undertaken a series of reviews of early childhood education and care in 12 member countries. The first reviews, published in an OECD report, *Starting Strong (2000)*, stressed the growing awareness that early childhood policy and services need to be part of a coherent, family-centred system. Twelve reports were included in the first series of reviews and several more reviews are currently underway. Canada, and Saskatchewan specifically, will be included in the 2003-04 reviews.

What happened in 2002-03 to improve early learning and care?

One way to accomplish positive outcomes for children is to ensure that parents have good choices available. While the concept of quality as it applies to early learning and care is complex, research clearly identifies certain factors that have an impact. Environmental features such as child to caregiver ratio, group size, and caregiver education and wages all impact quality.

Sixty-seven percent of Saskatchewan women with preschool-age children are in the paid labour force.

Wages

The quality of child care programs is improved when they are able to attract and retain qualified early childhood educators. $519,000 of ECD funding was invested in 2002-03 to help licensed child care centres improve wages for early childhood educators.

Professional Development

$500,000 of ECD funding supported enhancements to quality child care such as:

- funding for professional development activities for family child care providers and early childhood educators;
- increased start up funds to encourage new developments in licensed family child care; and
- expansion of equipment grants to enhance developmental programming in family child care.

Prekindergarten

Saskatchewan Learning's Prekindergarten Program was established in 1996-97 in partnership with school divisions that participate in the Community Schools Program. *Better Beginnings, Better Futures: Best Practices Policy and Guidelines for Prekindergarten in Saskatchewan Community Schools*, a policy direction and program guide, was developed to support school divisions to implement Prekindergarten. In 2002-03, there were 89 Prekindergarten programs supported by Saskatchewan Learning with up to 16 children in each program.

Prekindergarten is targeted to three- to four-year olds. Drawing on Saskatchewan's Kindergarten curriculum as its foundation, the program incorporates additional elements and adapts others to meet the needs of very young children living in vulnerable circumstances.

Specifically, early intervention Prekindergarten focuses on:

- fostering social development and self esteem;
- nurturing educational growth and school success;
- promoting language development; and
- involving families.

In both 2001-02 and 2002-03, $200,000 of ECD funding was allocated for Prekindergarten programs in non-targeted communities. Using social, health and economic indicators, four communities with significant numbers of vulnerable preschool children were selected: Estevan, Melfort, Swift Current and Weyburn.

Individual communities received $50,000 annually to operate the program. School divisions met with community agencies to plan the program. In Estevan, Melfort and Swift Current new programs were established. In Weyburn, an existing program was expanded. A total of 74 children and their families received support through the four new Prekindergarten programs.

Additional support services offered through the Prekindergartens in 2002-03 included: parent supports, transportation, speech and language, nutrition, dental and public health, family literacy and music and swimming programs.

"My child thoroughly enjoyed his Prekindergarten experience. I have been very pleased with my child's development since starting Pre-K and couldn't ask for better staff to be there. He will never have a better experience."

Swift Current Parent

Early Childhood Intervention Program (ECIP)

The first Saskatchewan Early Childhood Intervention Program (ECIP) was established in the spring of 1980. It provided home-based support to the families of children with disabilities including: hearing impairment, intellectual disabilities, visual impairment and multiple disabilities. The program was developed "to provide developmental training and service coordination to any infant or preschooler who is handicapped or at risk for handicapping conditions" and "to provide educational training and counselling for parents and families of the children in the program," (Saskatchewan Association for the Mentally Retarded, Prince Albert Branch, 1980).

These objectives continue to be met through comprehensive community and home-based support services including: screening, identification and assessment of the child; weekly or bimonthly home visits; development of individual child program and family support plans; referrals to required services; a resource and toy lending library; and parent support groups. Today there are 16 community-based, non profit ECIPs operating in Saskatchewan. Fifty-five early interventionists serve 696 children, birth to school age, and their families.

Since 2001-02, $370,000 of the ECD funding was allocated to children with developmental delays or those at risk for delay who would benefit from the Home-Based ECIP. All 16 non profit ECIPs across the province were invited to apply for funding to provide support and intervention to children on their waiting lists. Through an assessment tool that considered the degree of risk from the child's and the family's perspective, funding for 108 new spaces was directed to those agencies with children at greatest risk and in greatest need of support.

The following agencies received additional funding for new spaces: Meadow Lake and Area ECIP; Battlefords ECIP; Prince Albert ECIP; South East ECIP, Redvers; Alvin Bulkwold ECIP, Saskatoon Inc.; Swift Current and District ECIP; North East ECIP, Tisdale; Weyburn and area ECIP; Parkland ECIP, Yorkton; Children North ECIP, LaRonge; and Wecihik Awasisak Help the Children, Ile a la Crosse.

Infant Mortality Risk Reduction Initiatives

In Saskatchewan, and across Canada, infant mortality rates have dropped significantly over the last 20 years. In 1979, the infant mortality rate in Saskatchewan was 11.4 per 1,000 live births. In 2000, the figure had dropped to 6.8 per 1,000 live births. This is a 40 percent reduction in infant mortality.

In 2001-02, Saskatchewan Health identified five health regions that had high infant mortality rates and limited program and resource support. The five regions included:

- Mamawetan-Churchill River
- Keewatin Yatthe
- Heartland
- Prince Albert Parkland
- Athabasca Health Authority.

In 2002-03, a total of $71,500 was provided for the five regions to assess their needs and implement programs to reduce their risk of infant mortality. The activities included:

- Northern regions: nutritional education support for vulnerable prenatal women and families; educational resource material in health and pregnancy, parenting, Sudden Infant Death Syndrome, FASD and other alcohol-related disorders, addictions, injuries; and capacity building.
- Prince Albert-Parkland: training on appropriate and timely prenatal referral and parenting training.
- Heartland: workshops and training on targeting teen pregnancy; capacity building for prenatal referral/postnatal screening; and education and training of mothers.

These activities are ongoing and are expected to have a positive impact on the general health of infants in these regions and to contribute to a reduction in the risk of infant mortality.

ECD Strategy
The Path Forward

In 2002-03, significant work has been done to develop a strategic plan to guide the future development of KidsFirst. This work is ongoing; refinements to goals, objectives and indicators are being made in consultation with community partners. The goal is to ensure that the progress of families involved in the program can be tracked and that outcomes for children are measured. (See Appendix C for the Strategic Plan, as approved in 2002-03.)

Data is currently being gathered on KidsFirst program activity. Development of an information system for the program began in late 2002-03. Reporting on indicators has begun in the latter part of 2003-04.

The fiscal year 2002-03 was a productive and exciting one for the Early Childhood Development Strategy. In future years, the ECD Strategy will continue to address the province's early childhood needs. It will also work to continue to reduce the infant mortality rate in Saskatchewan.

Child Care Saskatchewan

In March 2003, the Government of Saskatchewan announced *Child Care Saskatchewan*, the largest expansion of funding for child care in Saskatchewan's history. Budget initiatives for the next fiscal year include $1.8 million for:

- 500 new licensed child care spaces in the 2003-04 year;
- Early Childhood Services grant funding to 250 existing unfunded child care spaces; and
- Capital funding for building developments, renovations, and fire safety requirements associated with child care spaces.

A $200,000 increase in Early Childhood Services grants addressed wage and human resource requirements associated with the new spaces. $1 million was allocated to increase child care subsidies for an average of $20 per month per child.

Appendix A

Summary of Investments — 2002-03

Implementation of Saskatchewan's Early Childhood Development (ECD) initiative has been helped considerably by the transfer of federal funding to the province.

The fiscal year 2002-03 saw the further development of the ECD Strategy, particularly the KidsFirst program. By fiscal year end, almost all targeted communities had fully implemented this program. However, because implementation was staged over the course of the year, expenditures did not match the federal funding. The province will ensure that all federal contributions for Early Childhood Development will be used for the purpose intended over the coming years.

Program Area	Expenditure
KidsFirst	
In non-targeted communities*	0
• Universal newborn screening	
• Realignment of existing programs	
In targeted communities	$ 6,753,469
• Prenatal screening and outreach	
• Birth screening and assessment	
• Home visiting	
• Mental Health and addictions	
• Enhanced child care	
• Early learning programs	
• Parenting supports	
Program Support	$ 646,001
Child Care	$ 1,019,000
• Training, wage enhancement and start up grants	
Early Intervention Spaces	$ 370,000
PreKindergarten Programs	$ 200,000
Infant Mortality Initiatives	$ 71,500
TOTAL	**$ 9,059,957**

*Funds for this year were expended by the province in 2001-02 and will be used by the communities in 2002-03.

Appendix B

Early Learning and Child Care — 2002-03

In their March 2003 Multilateral Framework on Early Learning and Child Care, Ministers Responsible for Social Services agreed to report annually to Canadians on their progress in improving access to affordable, quality early learning and child care programs and services. As part of this commitment, they agreed to begin their reporting with a baseline report outlining expenditures and programs in place during 2002-03.

Appendix B, along with the main text of this report, provides baseline information on programs and expenditures that receive financial support from the Saskatchewan government. It serves as a starting point for measuring the progress that will be made over the next few years as a result of the Ministers' Early Learning and Child Care Initiative.

1. Spaces

Child Care:

Number of licensed centres:	138
Number of licensed centre spaces:	5,123

Type of Space:	Number of Centre Spaces
Infants:	357
Toddlers:	980
Preschool:	2,949
School Age:	837
Total:	**5,123**

Number of licensed family child care homes:	277
Number of licensed family child care spaces:	2,160
Total Number Of Licensed Child Care Spaces:	**7,283***

*(*63 of these spaces are designated as KidsFirst spaces)*

Prekindergarten:

Number of programs:	89*
Number of spaces:	1,300* (based on average of 16 spaces per program)

**Includes four programs financed through federal Early Childhood Development funding that serve approximately 74 children and their families.*

Early Entrance Designated Disabled Pupil Program

Number of children:	289

2. Child Care Subsidy

Average number of subsidies:	3,353
Average monthly subsidy:	$241.92
Total Subsidy:	**$ 9,409,000**

3. Grants

Early Learning Programs:

Prekindergarten:	$4,000,000*[1]
Early Entrance Designated Disabled Pupil Program:	$2,800,000*

**Note: these are recognized expenditures and are cost shared by School Divisions through local tax base and the Government of Saskatchewan through the Foundation Operating Grant.*

[1] $200,000 of the Prekindergarten allocation is contributed by federal ECD funding.

Grants For Child Care Programs:

Early Childhood Services Grants:	$4,443,773 (plus $869,000 ECD)
Teen Support Grants:	$740,920
Preschool Support Grants:	$503,950
Start Up Grants:	$154,500 (plus $15,000 ECD)
Home Equipment/Programming Grants:	$143,434 (plus $50,000 ECD)
Special Northern Allowances:	$27,760
Community Solutions Grants (rural, workplace, special needs, etc.):	$611,363
Training /Education Grants:	$1,260 (plus $85,000 ECD)
Special Needs Grants:	$1,460,358
Total Child Care Grants:	**$8,087,318 (plus $1,019,000 ECD)**

4. Child Care Administration

Administration (licensing and subsidy):	$1,816,000

Appendix C

KidsFirst Strategic Plan 2002-03

The Strategic Plan presented here was approved for the 2002-03 fiscal year and was developed to guide implementation of the KidsFirst program. The Plan is evolving to reflect the realities of program delivery and to ensure the tracking of an increasing number of indicators. Further refinements to improve the ability of the program to track outcomes will likely be made.

KidsFirst Vision

Vulnerable children enjoy a good start in life and are nurtured and supported by caring families and communities. In targeted communities, supports and services are provided through partnerships between families, communities, service organizations and governments.

Goal 1: High risk children are born and remain healthy

Objectives

1. Improved prenatal care and support for pregnant women in the program.
2. Primary caregivers address their mental health and addictions issues.
3. Children maintain good physical health status or improved health status over time.

Goal 2: High Risk children are supported and nurtured by healthy, well-functioning families.

Objectives

1. Social support networks, housing, food security (availability), education, employment, and income for families will improve over time.

Goal 3: High risk children are supported to maximize their ability to learn, thrive and problem solve within their inherent capacity.

Objectives

1. Improve children's ability to learn.

Goal 4: High risk children and families are appropriately served by KidsFirst programs and supports

This goal relates to children's and families' satisfaction with services.

Objectives

1. Establish and maintain shared accountability mechanisms for processes and outcomes.
2. Create and maintain a service system for early childhood development that uses a community development approach, is built on existing services and is integrated, comprehensive, innovative, flexible and inclusive.
3. Identify appropriate families in a timely manner and retain them in the program.
4. Families satisfied with KidsFirst services.

Appendix D

Indicators of Child Well-Being in Saskatchewan

The primary influences on children occur within families. Families in turn are shaped by the physical and community environments in which they live. The linkage between physical surroundings and children's health and well-being has been observed for years. Research is providing evidence that growing up in a community that is perceived to have higher levels of cohesion, stability and social supports will lead to healthier child development. A growing number of comparable indicators are now becoming available for governments to use in a number of areas of interest — physical health, early development, safety and security, as well as family and community well-being.

First Ministers agreed to make regular public reports on indicators of child well-being using an agreed upon set of indicators. For 2001-2002 and 2002-2003, Saskatchewan has chosen to report on 23 indicators of child well-being. The data used to prepare these indicators comes from two primary sources - publicly available information provided by provincial and territorial governments that is compiled into national reports by the government of Canada, and survey-based information gathered through interviews of thousands of Canadian families as part of the National Longitudinal Study of Children and Youth (NLSCY). (See Appendix E for a description of the specific sources and data specificatons for each indicator.)

This report presents the information relating to the indicators and their importance as indicators of child well-being in general terms only and is not intended to provide an analysis of the data.

More detailed information is available on the Internet from both the government of Canada on the NLSCY (http://www11.hrdc-drhc.gc.ca/pls/edd/NLSCY.lhtml) and the government of Saskatchewan Comparable Health Indicators (http://www.health.gov.sk.ca/info_center_comparable_health_indicators_report.html).

Common Indicators of Child Well-Being

Physical Health

- *Healthy birth weight - high or low*
- *Immunization - Meningococcal disease*
  - Measles
  - Haemophilus influenza b (Hib)
- *Infant mortality rate*

Early Development, including social and emotional development

- *Physical health and motor development*
- *Emotional problem/anxiety*
- *Hyperactivity/inattention*
- *Physical aggression/conduct problem*
- *Prosocial behaviour*
- *Language skills*

Safety and Security

- *Injury mortality rate*
- *Injury hospitalization rate*

Family

- *Parental education*
- *Level of income*
- *Parental depression*
- *Tobacco use in pregnancy*
- *Family functioning*
- *Positive parenting*
- *Reading by adult*

Community

- *Neighbourhood satisfaction, safety, cohesion*

Saskatchewan child well-being is either consistent with, or can be favourably compared to, the national average in many areas. There are some indicators, however, that are of concern. For example, there is a higher incidence of infant mortality and smoking rates of pregnant women in Saskatchewan when compared to the Canadian average. Public health analysts monitoring this data have been highlighting these concerns for several years. It was concern over these negative indicators that, in part, spurred the province's interest in the ECD initiative and created the long-term preventive vision contained in KidsFirst.

Within the context of a Canada-wide Early Childhood Development initiative, this second report is a continuation of a comprehensive monitoring system of child well-being in Saskatchewan. This report contains data from a four-year period, 1998-2001. Physical health information such as birth rate, infant mortality, et cetera comes from the Canada Vital Statistics data base, with information supplied by provincial and territorial governments. All other data comes from survey information gathered as part of the National Longitudinal Study of Children and Youth (NLSCY). Not all indicator data was available at the time this report was written and is noted as missing on the charts affected.

While information is now available for up to four years, over time these indicators will provide useful baseline information for trend analysis. Seeing data over time is particularly important when using survey-based information such as the NLSCY and low-incidence data such as injury-related deaths and hospitalization and communicable diseases. The high degree of volatity in this data, from year to year, makes short term comparisons less reliable than is possible with more stable data, such as birth and infant mortality rates.

While Saskatchewan continues to be weaker on some indicators, there has been a stable, long-term trend to improvement. In some areas, such as early motor development, positive parental interaction, tobacco use during pregnancy and social development, Saskatchewan children and families appear to be doing better in 2001 than they were in 1998.

It is also important to note that these are general indicators of child well-being, which are impacted by the overall functioning of a society as well as by the multiplicity of programs available to the population. They are not intended to assess the impact of any particular program.

It should also be recognized that some gaps exist in the data. This results in an incomplete picture for some indicators and for some populations of children, most notably Aboriginal children. Efforts continue to improve data collection for future years.

Appendix D contains charts of baseline measures of Indicators of Child Well-Being. Appendix E provides data definitions and specifications for the indicators. These data compare Saskatchewan and Canada over four years, 1998-2001, or at single points in time in between 1998 and 2001. Readers should be mindful of the limitations and the restrictions imposed by the data definitions when interpreting this information.

Physical Health

The four indicators of Physical Health status included in this report use objective, administrative information gathered from hospitals and physicians.

Of the public health data indicators, healthy birth weight is seen as the key determinant of infant survival. Low birth weight babies are at higher risk of dying in their first year, and have a greater risk of disability and chronic medical difficulties in later life. Low birth weight is associated with poor maternal health, lifestyle and economic circumstances. High birth weight babies are also at higher risk for early death although the proportion of high birth weight infants who die is a fraction of the mortality rate of low weight infants.

Infectious diseases continue to affect thousands each year, although the mortality rate in all Canadian provinces has declined greatly in

recent years because of wide scale immunization programs and greater surveillance by families and health professionals. Tracking the incidence of diseases such as measles, meningoccocal disease and haemophilus influenza B provides an indication of periodic outbreaks of these diseases and the extent to which wide scale immunization practices have effect.

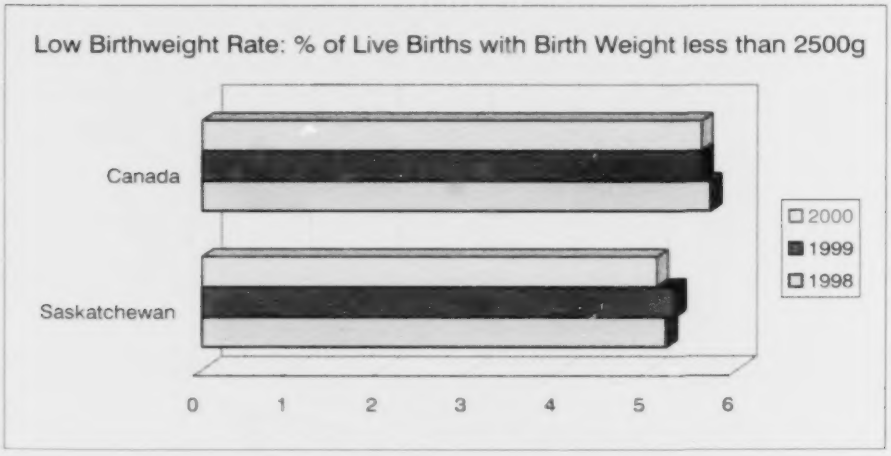
The high rate for haemophilus influenza-b in 1998-99 relates to a spike in infections for that year. The long-term trend shows that Saskatchewan has made great strides in decreasing the incidence of this disease and are now slightly below the Canadian average; there were no reported cases in Saskatchewan in 2000 or 2001.

Of all other indicators, infant mortality rates are recognized as one of the most important measures of child and maternal health status. A high rate is an indication of deficiencies in nutrition, socio-economic status, education or access to health care. Infant mortality is also strongly linked to maternal factors such as level of education, age, smoking and drug or alcohol abuse. Over the last 20 years, there has been a dramatic and steady decline in infant mortality in all provinces.

In Saskatchewan, the factors most responsible for high infant mortality rates are related to infant attributes (e.g. congenital defects, low birth weights, prematurity), as well as maternal characteristics (e.g. smoking, substance abuse, infection and disease during pregnancy, inadequate nutrition, low body weight before pregnancy, low socio-economic status and pregnancy in very young mothers). The high teenage pregnancy rate in Saskatchewan wields a strong negative influence on infant mortality

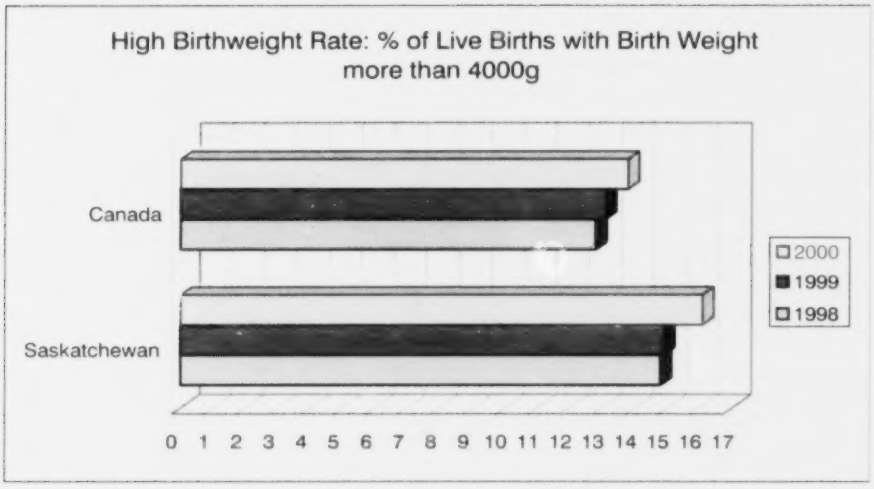
The reason for the higher than national average rate of injury hospitalizations in Saskatchewan is unknown. One possible reason is that many Saskatchewan children with injuries live in rural areas and often must travel to a larger urban centre for appropriate treatment. Often this transfer requires hospitalization whereas urban injuries are more often dealt with on an out-patient basis. More research is required to reveal reasons for this rate and programs will need to be developed to address this phenomenon.

Physical Health - Chart 1



Note: Data for 2001 not available at time of preparing this report.
Source: Canada Vital Statistics - Birth Database

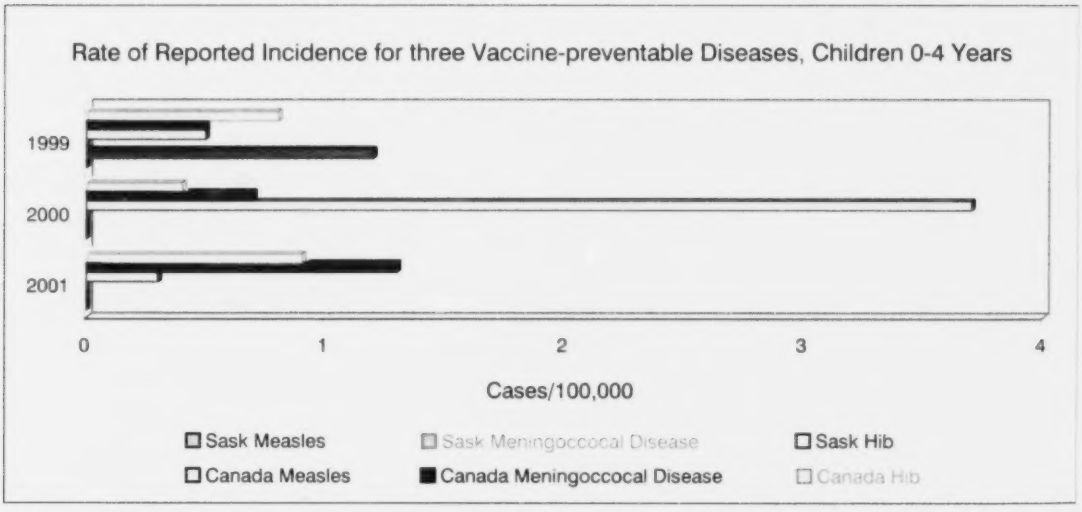
Physical Health - Chart 2


High Birthweight Rate: % of Live Births with Birth Weight more than 4000g
Canada
Saskatchewan
2000
1999
1998
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Note: Data for 2001 not available at time of preparing this report.

Source: Canada Vital Statistics - Birth Database

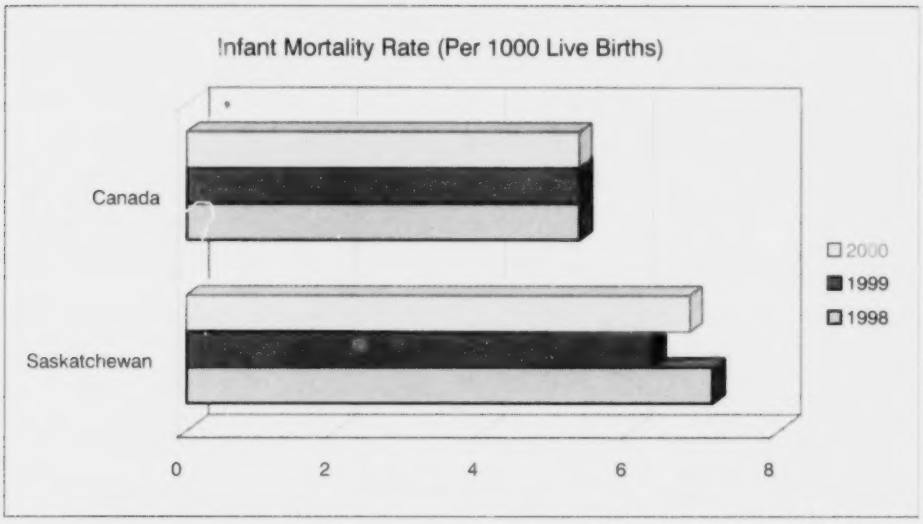
Physical Health - Chart 3



Measles and Meningoccocal Disease rates include children 0 to 5 years of age; Haemophilus Influenza B rates include children 0 to 4 years of age.

Source: Division of Immunization and Respiratory Diseases, Health Canada

Physical Health - Chart 4



Note: Data for 2001 not available at time of preparing this report.

Source: Canadian Vital Statistics - Mortality, Summary List of Causes

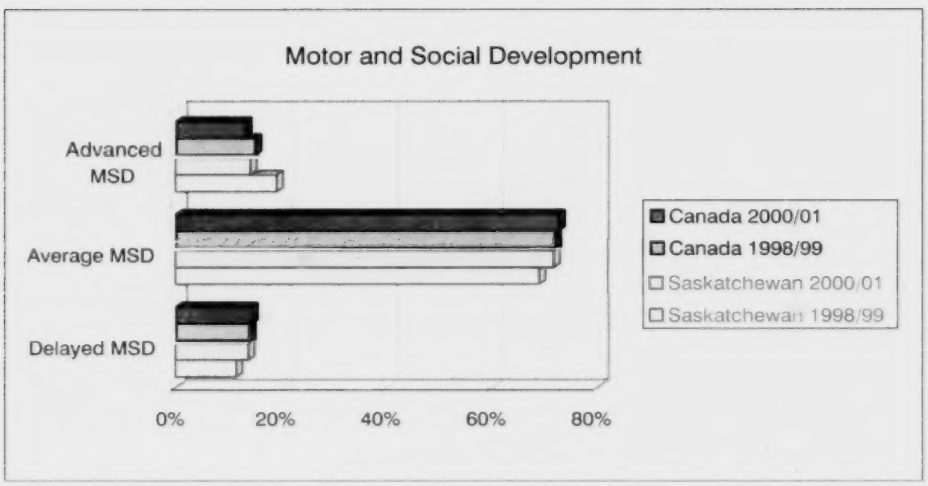
Early Development

Negative childhood behaviours such as low positive social behaviour, aggression, hyperactivity and emotional problems place children at a higher risk for life long difficulties, such as poor educational achievement, involvement with the justice system, violent behaviour as an adult and low socio-economic status. Although the frequency of these negative behaviours is more prevalent in adolescence, significant levels of these behaviours appear in early childhood. There are strong linkages between poor emotional health in children and weaker parenting styles and family dysfunction.

Scores on the Peabody Picture Vocabulary Test can a good predictor of later school success. In the NLSCY, the Peabody test was administered to four- and five-year-old children in the sample and, as such, can also provide some indication of school readiness by measuring verbal ability. There are strong linkages between PPVT scores and parenting style and education levels of parents. Socio-economic status is not closely linked to PPVT scores.

In 2000-01, the NLSCY questionnaire no longer included questions relating to prosocial behaviour. Instead, parents were asked questions about their baby's personal and social behaviour using a new instrument called "Ages and Stages." Parents were asked about their child's interaction with him or herself, with strangers, parents and objects such as toys. Although the two measures are different, they are both included on the Early Development Chart 2 - Emotional Health.

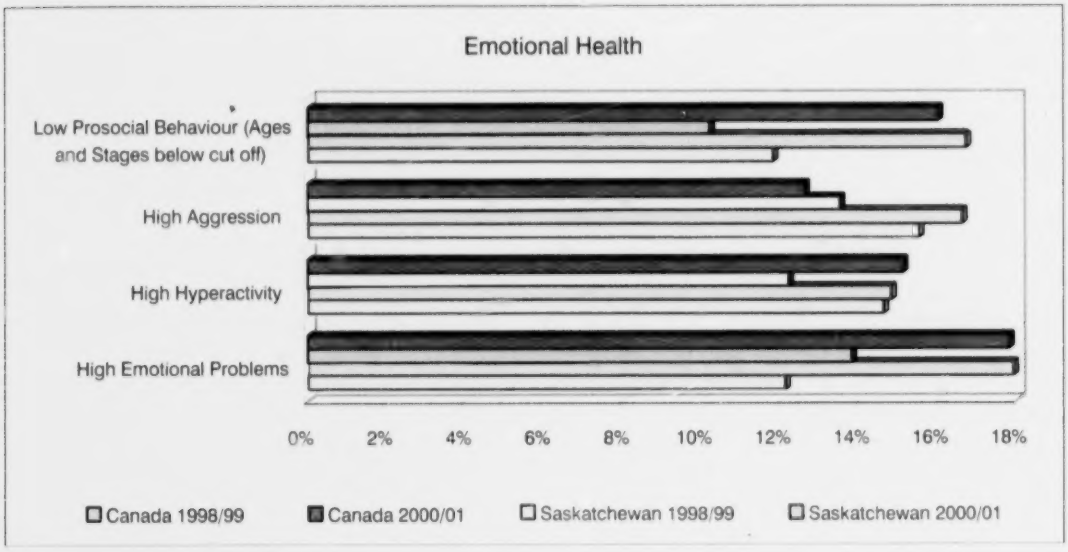
Early Development - Chart 1



Note: Based on standardized score for MSD

Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

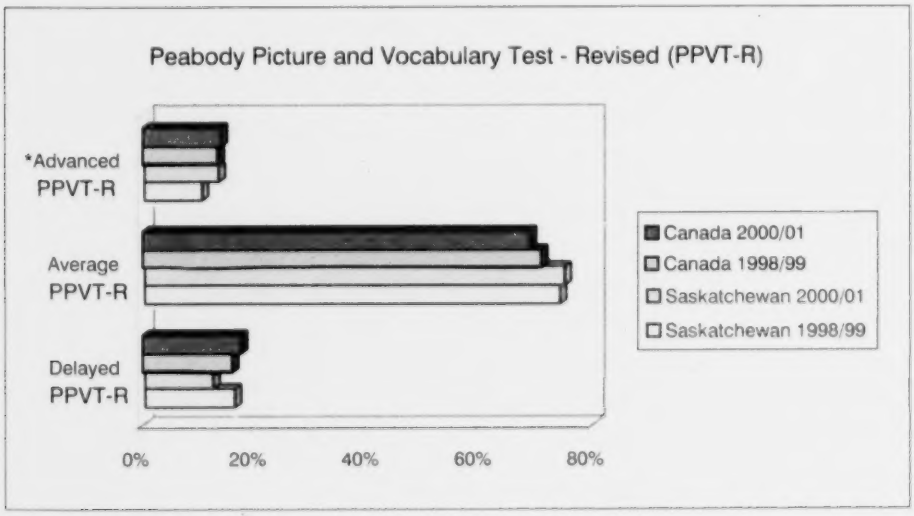
Early Development - Chart 2



Note: During Cycle 4 of the NLSCY, the measure for prosocial Behaviour was changed to the Ages and Stages developmental Index.

Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Early Development - Chart 3



**"Marginal" data quality*

Note: Based on Standardized score for PPVT-R

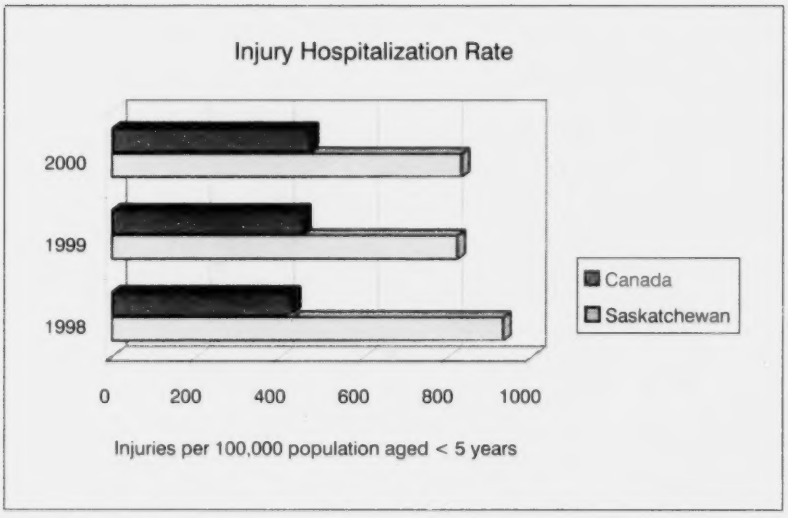
Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Safety and Security

Injury mortality and injury hospitalization rates are public health measures of reported cases of hospitalization or death due to injury. Safety equipment like seat belts in automobiles, helmets for motorcycles and snowmobiles and lifejackets for watercraft have dramatically reduced injury and death. Considerable variation in injury mortality rates across the country is reflective of differences regionally and locally with respect to such things as lifestyle, farming or ease of access to emergency services in remote areas. Injury rates are also strongly related to income levels, family composition and household size. Rates are highest on Canada's reserves and in poor urban neighbourhoods.

Happily, relatively few young children die as a result of injury. Because of the small number of cases of injury requiring hospitalization or resulting in death, however, even a single case can greatly affect the rate per 100,000 cases. Readers need to exercise caution when reading the following two charts as this is a major limitation of this indicator.

Safety and Security - Chart 1

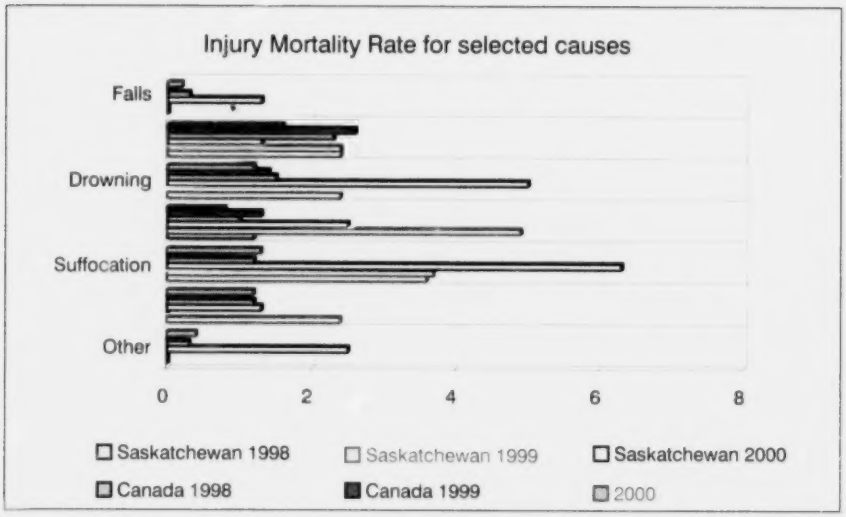


**P/T of residence used.*

Note: Dis-aggregated data unavailable at time of writing.

Source: Canadian Vital Statistics - Mortality, Summary List of Causes

Safety and Security - Chart 2



Source: Canadian Vital Statistics - Morbidity, Summary List of Causes

Family-Related Indicators

While parental educational attainment is linked to many of the indicators of child well-being included in this report, researchers have so far been unable to precisely determine how education levels of parents influence child developmental and educational outcomes. Parents with higher education are more likely to hold higher paying jobs, place a higher value on education and spend more time reading to their children or helping with homework. All these factors contribute to improved educational outcomes. Further study will improve the understanding of the effect of education levels of parents.

Low Income Cut Off Rates (LICOs) are income thresholds determined by analyzing family expenditure data obtained through the Survey of Labour Market and Income Dynamics, Statistics Canada, which samples information from a large survey of Canadian families. The LICO is the threshold below which families will likely devote a larger share of their income to the basic necessities of food, shelter and clothing than the average family would. LICOs are often, mistakenly, referred to as poverty lines. There is no official designation of LICOs as such. Because LICOs are relative measures of all income levels, considerable variation can occur from year to year.

Tobacco use is the leading cause of preventable illness and death in Canada. While secondhand smoke is a serious health risk for everyone, fetuses and young children are particularly susceptible to the harmful effects of tobacco smoke in their environment. These effects include stillbirth, low birth weight, increased risk of sudden infant death syndrome, reduced lung development and increased incidence and severity of respiratory illness. Reducing the number of women who smoke during pregnancy is an important public health objective. Smoking rates are highest among young women, poor people and those in remote communities. Those who smoke also have higher rates of alcohol and drug abuse.

Depressed parents are usually withdrawn, tired, despondent and pessimistic about the future. These are not healthy influences as children raised by a depressed parent (particularly

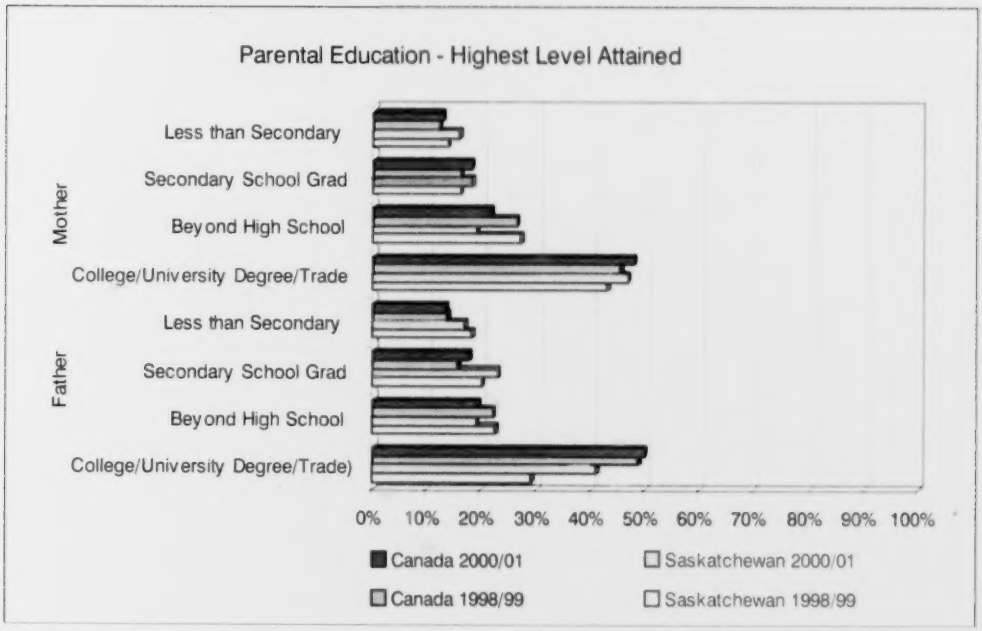
mothers) are more likely to have behaviour problems and poor cognitive development. Children in low-income households are at higher risk of having a depressed parent.

In the NLSCY, family functioning was measured by asking parents a number of questions about problem solving practices, expressive communication, decision-making and levels of acceptance. Families with low scores exhibit a high degree of dysfunctional behaviour. This kind of family environment increases the likelihood of childhood behaviour and emotional problems such as aggression and anxiety.

In the NLSCY, parents were asked how often they engaged in a number of positive parenting interactions with their children, such as praise, playing together and laughing together. Children whose parents do not frequently engage in these types of positive interactions have a higher risk for poor motor and social development and the development of negative social behaviours as they grow up.

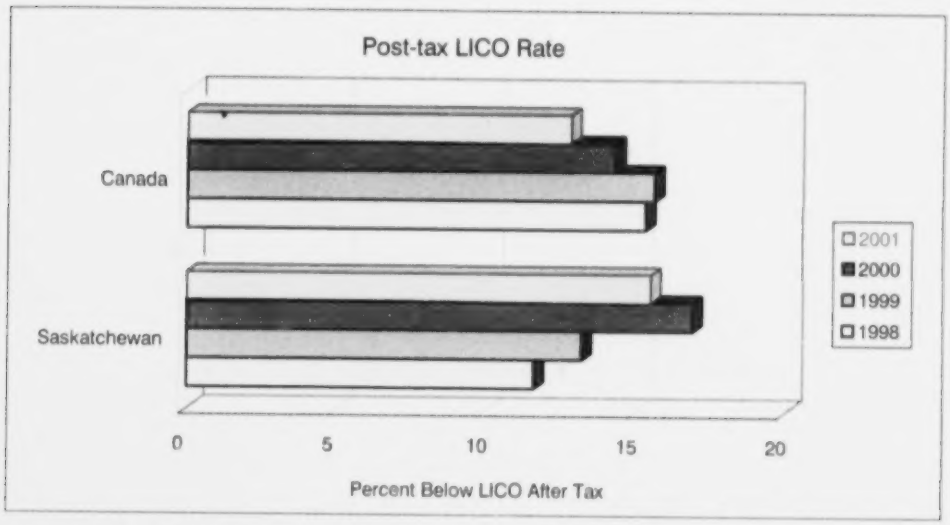
Adults who read to their children have a positive impact on children's educational outcomes. In general, the more frequently a child is read to, the more positive the benefits in vocabulary and reading comprehension during the earlier years of school.

Family Related Indicators - Chart 1



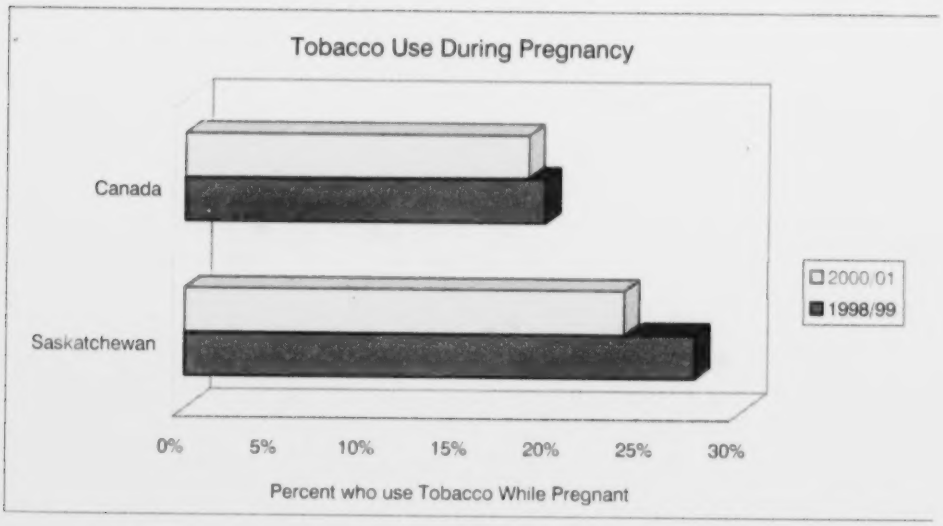
Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Family Related Indicators - Chart 2



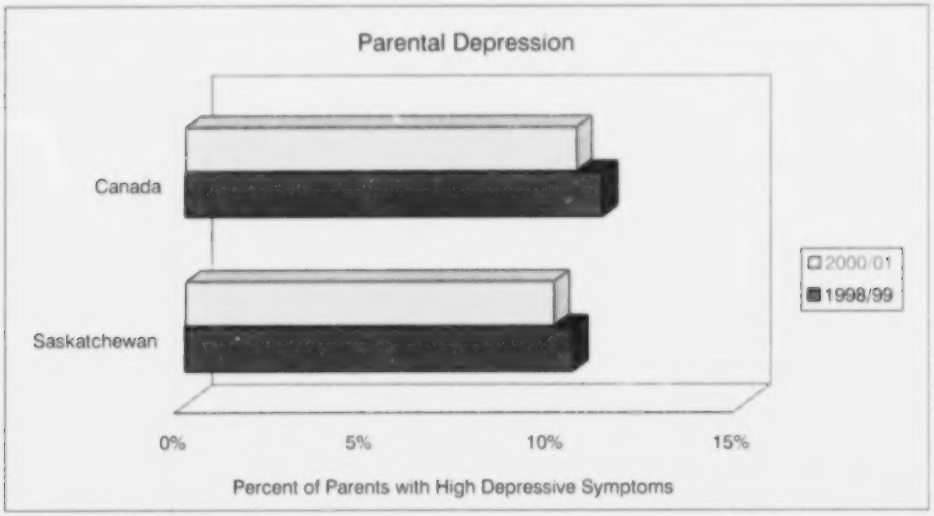
Note: Population level Families with children 1 to 5 years of age (included).
Source: Survey of Labour and Income Dynamics: Reference years 1998-2001.

Family Related Indicators - Chart 3



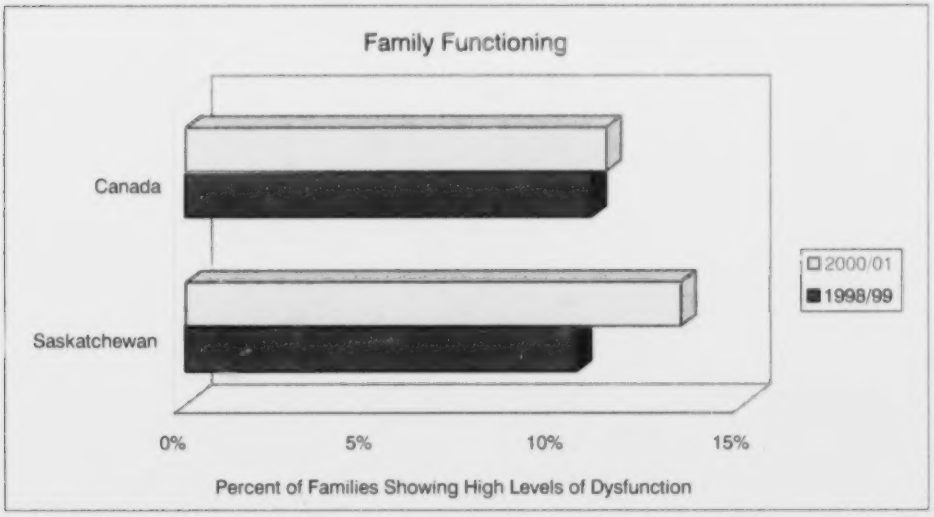
Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Family Related Indicators - Chart 4



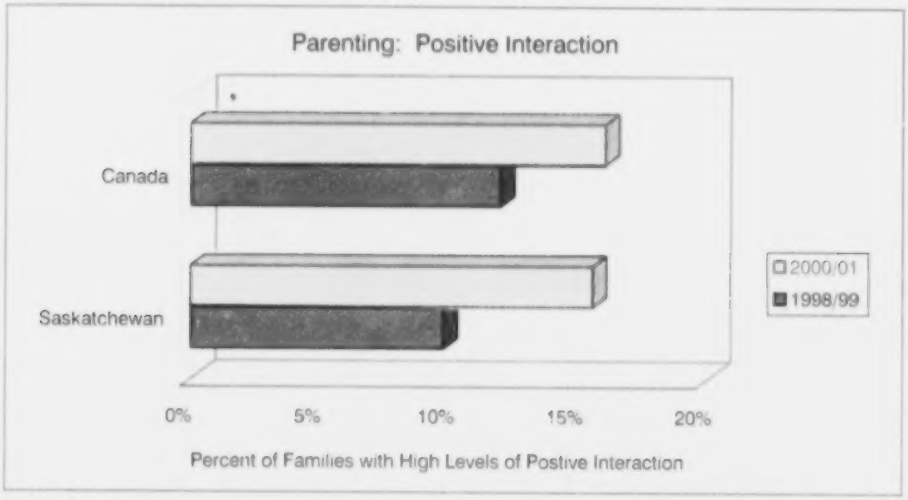
Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Family Related Indicators - Chart 5



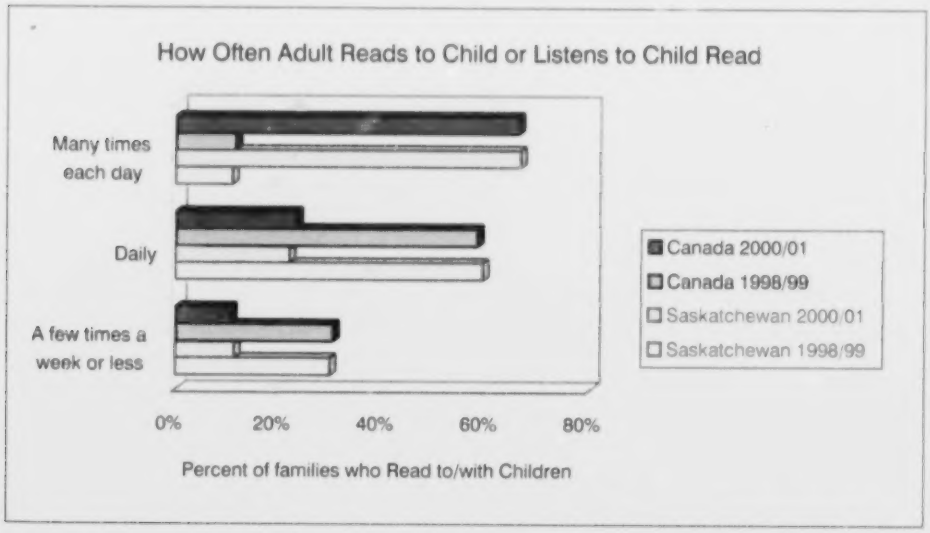
Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Family Related Indicators - Chart 6



Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Family Related Indicators - Chart 7



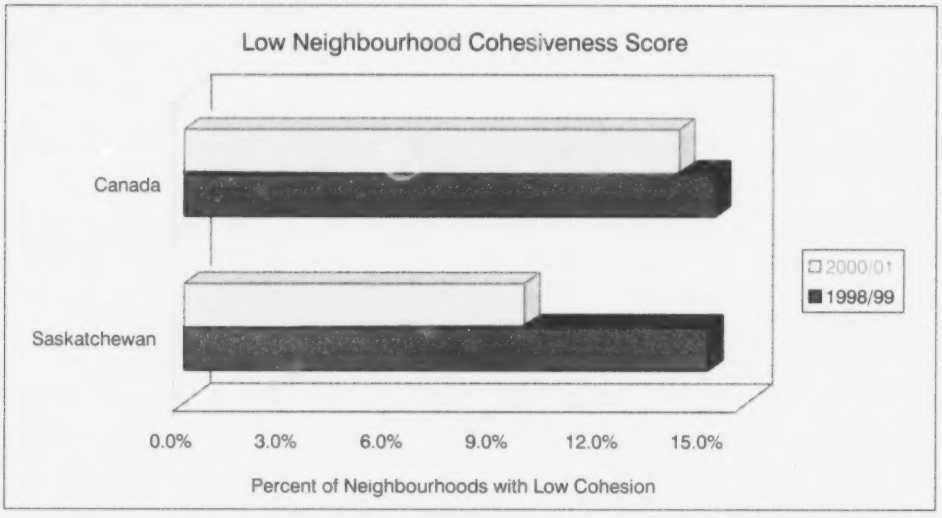
Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Community-Related Indicators

The neighbourhood cohesiveness score is based on perceptions of trust of neighbours, the presence of adults children can look up to, cooperation of neighbours in dealing with problems, watching out for children's safety and keeping an eye on neighbours' property when they are away. Children growing up in neighbourhoods with low levels of cohesiveness are less likely to be ready for school.

In 2000-01, an additional series of questions were included in the NLSCY survey of families on neighbourhood safety.

Community Related Indicators - Chart 1



Source: NLSCY, Cycle 3 and 4 (1998/99, 2000/01), Master File, Parents Questionnaire; data presented is weighted.

Appendix E
Data Specifications

Specifications for the Indicators of Child Well Being

Within the area of "Early Development," federal, provincial and territorial governments have agreed to report on the following indicators:

A. Physical Health and Motor Development
B. Emotional Health (comprised of (i) Emotional Problem/Anxiety and (ii) Hyperactivity)
C. Social Knowledge and Competence (comprised of (i) Physical Aggression/Conduct Problems and (ii) Personal-Social Behaviour - formerly Prosocial Behaviour)
D. Language Skills

Information on Physical Health and Motor Development, Emotional Problem/Anxiety, Hyperactivity, Physical Aggression/Conduct Problems and Language Skills has not changed and is consistent with the information reported in 2002. Detailed specifications can be found below in C Social Knowledge and Competence (page 38).

In the National Longitudinal Study on Children and Youth (NLSCY) Cycle 4 (2000-2001), Prosocial Behaviour was no longer collected. A new instrument was included entitled "Ages and Stages" (see page 38). The "Ages and Stages" questionnaire includes a section on "personal-social" elements of the child's behaviour. This includes such items as how the baby interacts with him/herself, with strangers, with the parent and with objects such as toys. Responses are scored and a scale can be derived to determine if the child is performing to an age-appropriate level or not. This information replaces the prosocial behaviour reported in 2002. Technical information on the indicator can be found below

Physical Health

A. Healthy Birthweight

(i) Low Birthweight

Measure:
Low Birthweight Rate

Definition:
The percentage of live births with birthweight less than 2500 grams. The low birthweight rate = (number of live births with birthweight less than 2500g / number of all live births) * 100.
Source: Statistics Canada

Exclusions:
Births with unknown birthweight; births to non-Canadian residents.

(ii) High Birthweight

Measure:
High Birthweight Rate
Definition:
The percentage of live births with birthweight greater than 4000 grams. The high birthweight rate = (number of live births weighing greater than 4000g / number of all live births) *100.
Source: Canadian Vital Statistics - Birth Database (Statistics Canada).

Exclusions:
Births with unknown birthweight; births to non-Canadian residents.

B. Immunization

(i) Meningococcal Disease

Measure:
Invasive meningococcal disease incidence rate
Definition:
The rate of new cases reported by year for children five years of age and younger.
Notes for Interpretation:
A new generation of very effective protein conjugate vaccines is now available against Group C disease which can be given to infants as young as two months of age. The National Advisory Committee on Immunization (NACI) recommends three doses of this vaccine at two, four and six months of age for routine immunization.
The meningococcal disease incidence rate = (number of cases / total population under five years) *100,000.

Source:
Division of Immunization and Respiratory Diseases, Health Canada

Exclusions: Not Applicable.

(ii) Measles

Measure:
Measles incidence rate for children five years of age and younger.
Definition:
The rate of new cases reported by year. A confirmed case is defined as laboratory confirmation of infection in the absence of recent immunization with measles-containing vaccine: isolation of measles virus from an appropriate clinical specimen or significant rise in measles specific antibody titre. Between acute and convalescent sera or positive serologic test for measles IgM using a recommended assay or clinical case in a person who is epidemiologically linked to a laboratory confirmed case.
Source:
Division of Immunization and Respiratory Diseases, Health Canada

Exclusions: Not Applicable

(iii) Haemophilus Influenza b (HIb) Disease in Children

Measure:
Haemophilus influenzae-b (Invasive) disease incidence rate in children under five years.
Definition:
The rate of new cases reported by year in children less than five years of age.
Notes for Interpretation:
A confirmed case is defined as invasive disease with laboratory confirmation of infection in the absence of recent immunization with HIb-containing vaccine: isolation of H. influenzae type b from a normally sterile site or epiglottis in a person with epiglottitis, or demonstration of H. influenzae type b antigen in cerebrospinal fluid. Invasive disease includes meningitis, bacteraemia, epiglottitis, pneumonia, pericarditis, septic arthritis or empyema.
The HIb incidence rate = (number of cases / total population ages zero to four years) *100,000.

C. Infant Mortality Rate

Measure:
Infant Mortality Rate
Definition:
The number of children who die in the first year of life per 1,000 live births.
The infant mortality rate = (number of deaths in children aged less than one year/number of all live births) * 1000.
Source:
Canadian Vital Statistics - Mortality, Summary List of Causes (Statistics Canada).

Exclusions: Not Applicable.

Early Development

Includes the following indicators:

E. Physical Health and Motor Development
F. Emotional Health (comprised of (i)Emotional Problem/Anxiety and (ii) Hyperactivity)
G. Social Knowledge and Competence (comprised of (i) Physical Aggression /Conduct Problems and (ii) Prosocial Behaviour)
H. Language Skills

A. Physical Health and Motor Development

Measure:
Motor and Social Development (MSD)
Definition:
The proportion of children aged zero to three years who have delayed, average and advanced levels of motor and social development.
The Motor and Social Development scale consists of a set of 15 questions that measure dimensions of the motor, social and cognitive development of young children from birth through three years; the questions vary by age of the child. These questions are asked of the Person

Most Knowledgeable (PMK) of the child[1].
The standardized score is being used for this indicator, in which the average score for the population is set at 100 with a standard deviation of 15. The standardized score takes account of the child's age and allows for comparisons of scores to be made across age groups.
Based on the score:
"delayed" = children scoring from 0-84 on the scale (one standard deviation below the mean and lower).
average" = children scoring between 85-115 on the scale (a range from one standard deviation below the mean to one standard deviation above the mean).
"advanced" = children scoring 116+ on the scale (one standard deviation above the mean and higher).
Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.
Exclusions:
Children aged four to five years; children living in the Territories; children living on reserve; children living in institutions.

B. Emotional Health

(i) Emotional Problem/Anxiety

Measure:
Emotional Problem - Anxiety Score
Definition:
The proportion of children aged two to five years who exhibit high levels of emotional and/or anxiety problems.
Emotional problem/anxiety is one of a number of behaviour scales examined in NLSCY. The purpose of the behaviour scales is to assess the extent of the presence or absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

Technical Notes:
Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:
Children aged zero to one year; children living in the Territories; children living on reserve; children living in institutions.

(ii) Hyperactivity

Measure:
Hyperactivity - Inattention Score
Definition:
The proportion of children aged two to five years who exhibit high levels of hyperactivity and/or inattention.
Notes for Interpretation:
Hyperactivity/inattention is one of a number of behaviour scales examined in the NLSCY. The purpose of the behaviour scales is to assess the extent of the presence or absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.
Source:
National Longitudinal Survey of Children

[1] *DEFINITION: PMK (Person Most Knowledgeable) in the NLSCY*

In the NLSCY, a question was asked about who in the household was the person most knowledgeable (PMK) about the child participating in the survey. The intention was that the PMK, in most cases the mother, would provide information for all selected children in the household, as well as the sociodemographic information about herself and her spouse. The latter information was used to describe the socioeconomic situation of the child's family. Only one PMK was selected per household.

and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:
Children aged zero to one year; children living in the Territories; children living on reserve; children living in institutions.

C. Social Knowledge and Competence

(i) Physical Aggression/Conduct Problems

Measure:
Physical Aggression Score
Definition:
The proportion of children aged two to five years who exhibit high levels of physical aggression, opposition and/or conduct disorder.
Notes for Interpretation:
Physical aggression is one of a number of behaviour scales examined in the NLSCY. The purpose of the behaviour scales is to assess the extent of the presence or absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

Technical Notes:
Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

(ii) Prosocial Behaviour

Measure:
Prosocial Behaviour Score
Definition:
The proportion of children aged two to five years who exhibit low levels of prosocial behaviour.
Notes for Interpretation:
Prosocial behaviour is one of a number of behaviour scales examined in the NLSCY. The purpose of the behaviour scales is to assess the extent of the presence or absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

Technical Notes:
Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:
Children aged zero to one year; children living in the Territories; children living on reserve; children living in institutions. Children whose actual age at the time of interview was one year have been removed from this estimate.

(ii) Ages and Stages - Personal Score

Measure:
Personal Score
Definition:
The proportion of children aged zero to three years who do not exhibit age appropriate personal-social behaviours.
Notes for Interpretation:
Personal-social behaviour is one of a number of behaviour scales examined in the Ages and Stages questionnaire, a supplement to the NLSCY. The questions are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

To identify those children who do not exhibit age appropriate personal-social behaviours, thresholds (or cut-off points)

were established by taking the scale score that is one standard deviation below the mean based on Cycle 4 data for children in all provinces. The variable represents the proportion of children who do not exhibit age appropriate personal-social behaviour.

Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 4 (2000/01), Ages and Stages Questionnaire

Exclusions:
Children aged four to five years; children living in the Territories; children living on reserve; children living in institutions.

Operationalization:
The scale for personal-social behaviour is comprised of several questions capturing different age-relevant aspects of this behaviour such as how the baby interacts with him/herself, with strangers, with the parent and with objects such as toys. The scale ranges from 0-60, with a low score indicating decreased levels of age appropriate behaviour.

For the purposes of ECD reporting, a threshold was established to determine those children who are not exhibiting age appropriate behaviour and those who are. The threshold is one standard deviation below the mean which, for this sample, is represented by a score of 35. Therefore, those children whose score was 35 or lower were identified as not exhibiting age appropriate personal-social behaviour, while those with a score of 36 or higher were identified as exhibiting age appropriate personal-social behaviour.

D. Language Skills

Measure:
Standard Score for PPVT-R (Peabody Picture and Vocabulary Test - Revised)
Definition:
The proportion of children aged four to five years who have delayed, average and advanced levels of receptive or hearing vocabulary.
The PPVT-R is designed to measure receptive or hearing vocabulary in either English or French. The test is administered by the interviewer directly to children aged four to five years and to children aged six years and older who were not yet in Grade 2 at the time of the interview. The PPVT-R is only administered to children whose PMK provided consent for the test to be administered to their child.
The standardized score is being used for this indicator, in which the average score for the population is set at 100 with a standard deviation of 15. This standardization was done by two month age groups. The standardized score takes account of the child's age and allows for comparisons of scores to be made across age groups. Based on the standardized score:
"delayed" = children scoring from 0-84 on the scale (one standard deviation below the mean and lower).
"average" = children scoring between 85-115 on the scale (a range from one standard deviation below the mean to one standard deviation above the mean).
"advanced" = children scoring 116+ on the scale (one standard deviation above the mean and higher).
Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Direct Assessment
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.
Exclusions:
Children aged zero to three years; children aged four to five years for whom the PMK did not provide consent for the PPVT-R to be administered; children living in the Territories; children living on reserve; children living in institutions.

Safety and Security

Includes the following indicators:

A. Injury Hospitalization Rate
B. Injury Mortality Rate

A. Injury Hospitalization Rate

Measure:
Injury Hospitalization Rate
Definition:
The proportion of children aged zero to five years who are hospitalized for treatment of injuries.
Data on the injury hospitalization includes the following types of injuries:
- Motor vehicle traffic crashes
- Falls
- Other unintentional
- Self-Inflicted
- Assault
- Other

The injury hospitalization rate = (number of hospitalizations for treatment of injuries/total population aged less than five years)*100,000.
Source:
Canadian Institute for Health Information (CIHI) - hospital records

B. Injury Mortality Rate

Measure:
Injury Mortality Rate
Definition:
The proportion of children aged zero to five years who die as a result of an injury.
Data on the injury mortality rate includes the following types of injuries:
- Motor vehicle traffic crashes
- Falls
- Other unintentional
- Self-Inflicted
- Assault
- Other

The injury death rate = (number of deaths resulting from an injury/total population)*100,000.
Source:
Canadian Vital Statistics - Mortality Database (Statistics Canada).
Exclusions:
Non-Canadian residents.

Family-Related Indicators

Includes the following:

A. Parental Education (comprised of (i). mother's highest level of education and (ii) father's highest level of education)
B. Level of Income (comprised of (i). pre-tax LICO, (ii) post-tax LICO and (iii) post-tax LIM)
C. Parental Health - Parental Depression
D. Parental Health - Tobacco Use During Pregnancy
E. Family Functioning
F. Positive Parenting
G. Reading by Adult

A. Parental Education

(i.) Mother's Highest Level of Education

Measure:
Mother's highest level of education
Definition:
The highest level of education attained by the mother of children aged zero to five years.
Highest level of education has been disaggregated into four categories:
- Less than secondary school
- Secondary school graduation
- Beyond secondary school (but has not achieved postsecondary school diploma/degree)
- College or university degree (including trade).

Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.
Exclusions:
Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster mother; children living in the Territories; children living on reserve;

children living in institutions.

(ii.) Father's Highest Level of Education

Measure:
Father's highest level of education
Definition:
The highest level of education attained by the father of children aged zero to five years.
Highest level of education has been disaggregated into four categories:
- Less than secondary school
- Secondary school graduation
- Beyond secondary school (but has not achieved postsecondary school diploma/degree)
- College or university degree (including trade).

Source:
National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:
Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster father; children living in the Territories; children living on reserve; children living in institutions.

B. *Level of Income*

(i.) Pre-Tax Low-Income Cut-Off (LICO)

Measure:
Pre-Tax LICO Rate
Definition:
The proportion of children aged zero to five years living below the pre-tax LICO.
The Low-Income Cut-Off is a relative measure based on the percent of income spent on basic needs by an average family. The pre-tax LICO is set according to the proportion of annual pre-tax income (total income including government transfers before the deduction of income taxes) spent on basic needs (food, clothing and shelter). A household that spends 20 percent more on basic needs than the average family is considered to be living below the low-income cut-off. The LICO is adjusted for location and family size.

Source:
Survey of Labour and Income Dynamics (SLID) - Statistics Canada, Reference Years 1998 and 1999.

Exclusions:
Children living in the Territories.

(ii.) Post-Tax Low-Income Cut-Off (LICO)

Measure:
Post-Tax LICO Rate
Definition:
The proportion of children aged zero to five years living below the post-tax LICO.
Notes for Interpretation:
The Low-Income Cut-Off is a relative measure based on the percent of income spent on basic needs by an average family. The post-tax LICO is set according to the proportion of annual post tax income (total income after the deduction of income taxes) spent on basic needs (food, clothing and shelter). A household that spends 20 percent more on basic needs than the average family is considered to be living below the low-income cut-off. The LICO is adjusted for location and family size.

Source:
Survey of Labour and Income Dynamics (SLID) - Statistics Canada, Reference Years 1998 and 1999.

Exclusions:
Children living in the Territories.

C. *Parental Health - Parental Depression*

Measure:
Parental Depression
Definition:
The proportion of children aged zero to five years whose PMK exhibits high symptoms of depression.
The Depression scale in the NLSCY represents a condensed version of the Depression Rating Scale (CES-D). This

scale measures the occurrence and severity of symptoms associated with depression in the public at large and does not represent the occurrence of clinically diagnosed depression. The scale ranges in value from 0-36 with high scores indicating the presence of depressive symptoms. This scale is administered to the person most knowledgeable (PMK) about the child.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

D. *Parental Health - Tobacco Use During Pregnancy*

Measure:

Smoking During Pregnancy

Definition:

The proportion of children aged zero to one year whose mother smoked during her pregnancy with the child.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged two to five years; children living in the Territories; children living on reserve; children living in institutions.

E. *Family Functioning*

Measure:

Family Functioning

Definition:

The proportion of children aged zero to five years in families with high levels of dysfunction.

The family functioning scale provides a global assessment of family functioning (including problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control) and indicates the quality of relationships between family members. This scale is administered to either the person most knowledgeable (PMK) about the child or the spouse/partner. The scale ranges in value from 0-36 with higher scores indicating family dysfunction. The scale does not reflect a clinical diagnosis.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

F. *Positive Parenting*

Measure:

Positive Interaction

Definition:

The proportion of children aged zero to five years whose parents exhibit low positive interaction with the child. Positive interaction is a parenting style that is captured in the NLSCY. The purpose of the parenting scales is to measure certain parental behaviours. The scale ranges in value from 0-20, with high scores indicating positive interaction with the child. The questions assessing parenting styles were administered to the person most knowledgeable (PMK) about the child or spouse/partner of the PMK.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

G. Reading by Adult

Measure:

Reading by Adult

Definition:

Distribution of children aged two to five years by how often an adult reads to the child or listens to the child read.

This indicator refers to the exposure of the child to reading activities with a parent or another adult. Therefore, this indicator should not be interpreted to refer specifically to parent-child interactions.

The frequency that an adult reads to child or listens to child read has been aggregated into the following categories:

- A few times per week or less
- Daily
- Many times each day.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged zero to one year of age; children living in the Territories; children living on reserve; children living in institutions.

Community--Related Indicators

A. Neighbourhood Satisfaction, Safety and Cohesion

Within the area of "Community-related indicators", federal/provincial/territorial governments have identified one indicator that they may choose to report:

• Neighbourhood Satisfaction, Safety and Cohesion

NLSCY Cycle 3 (1998/99) included only one element of this indicator - Neighbourhood Cohesion. NLSCY Cycle 4 (2000-01) also includes a measure of Neighbourhood Safety. Information on both measures is provided below.

Measure:

Neighbourhood Cohesion

Definition:

The proportion of children aged zero to five living in neighbourhoods with low neighbourhood cohesion, as judged by the PMK.

The purpose of the neighbourhood scales is to assess the extent of the presence/absence of certain neighbourhood characteristics. In particular, the neighbourhood cohesion scale can be used to measure the social unity of a neighbourhood (the extent to which the PMK about the child feels that there is cohesion in the neighbourhood). The scale ranges in value from 0-15 with higher scores indicating neighbourhood cohesion in the child's neighbourhood.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

Appendix E - Part 2

Data Specifications

Description of Data Quality Guidelines for Presentation of Indicators Based on the National Longitudinal Survey of Children and Youth.

According to Statistics Canada, there are three different quality levels of the estimate (cell count) on the spreadsheets on which the preceding graphs are based:

"acceptable" = sample size of 30 or more cases and a low coefficient of variation (between 0 - 16.5 percent). For this level, no warning is required.

"marginal" = sample size of 30 or more cases and high coefficient of variation (between 16.6 percent - 33.3 percent). For this level estimates must be flagged with an asterix (*) and be accompanied by the following warning: "While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it."

"unacceptable" = sample size of less than 30 cases or a very high coefficient of variation (in excess of 33.3 percent). For this level estimates must be flagged with a double asterix (**) and be accompanied by the following warning: "The following estimate does not meet Statistics Canada's quality standards for this statistical program. Conclusions based on these data will be unreliable and most likely invalid. These data and any consequent findings should not be published."

In the development of the common set of 11 indicators related specifically to child outcomes, as well as the additional 12 indicators related to child and environmental (family and community) outcomes, data of unacceptable quality (i.e. cells with less than 30 cases) has already been suppressed.

Statistics Canada has a long standing policy that sample weights for surveys are calculated using the most reliable population counts available for the appropriate point in time. For intercensal years, these weights are typically based on population estimates. Once more reliable population counts become available (primarily via the Census, which is conducted every five years), the initial weights for the intercensal years are adjusted to reflect the final population counts.

Updating the sample weights for surveys such as the National Longitudinal Survey of Children and Youth (NLSCY) and Survey of Labour and Income Dynamics (SLID) is essential to ensure consistency between Statistics Canada's official population figures and the survey estimates.

In order to ensure comparability between the data reported for 1998/1999 and 2000/2001, all NLSCY and SLID based indicators for 1998/99 are being re-reported to reflect the revised weights. For those indicators based on the NLSCY, the Cycle 3 (1998/99) weight now reflects the population on January 1, 1999 according to the 2001 Census. For those indicators based on the SLID, the 2000 historical weight has been revised to population counts based on the 1996 Census.

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